New York State Young Birders Club Field Trip Registration Form – 2017

Student's Name_____ Date of Birth _____

Address_____ City_____ State____ Zip_____

Home Phone_____ Parent's Cell Phone_____ Student's Cell_____

How will student get to and return from these events? (check all that apply) ☐Car ☐Public Transport. ☐Walk

Other (please explain): _____

If by car, who will be driving? _____ Relationship to student_____

I hereby give permission for the above named young birder to participate in the field trips marked "Yes" below of the New York State Young Birders Club (NYSYBC), a program of the New York State Ornithological Association, Inc. (NYSOA). I assume all risks and hazards incidental to the activities of the event and transportation to, from, and during the event. I further release, absolve, indemnify, and hold harmless the New York State Young Birders Club, the New York State Ornithological Association, and all organizers, sponsors, leaders, chaperones, and supervisors of the event. In case of injury, I hereby waive all claims against all organizers, sponsors, leaders, and supervisors. I likewise release from responsibility any person transporting my child to, from, and during the scheduled activities.

Bashakill WMA (Sullivan County) 5/7/17 ☐**Yes** ☐**No**

Trip information available at www.nysyoungbirders.org. Also watch for email updates.

Parent/guardian information & signature (below) required for all participants under age 18

Note: Parents are encouraged to participate in field trips and other NYSYBC activities!

Consent or Non-Consent to Use of Photographs

From time to time throughout the year, an occasion may arise where we would like to publish a photo of the young birder named above in the newspaper, NYSOA and/or NYSOA member club newsletter and/or website, NYSYBC newsletter and/or website, or a similar publication. WE DO NOT IDENTIFY MINORS IN IMAGES ON THE NYSYBC website.

Please ***initial*** *DO or DO NOT:* **By signing below, I _____DO _____DO NOT give permission to use images of the young birder named above in the manner described.**

Name of parent or legal guardian (please print):_____

_____ Signature of parent or legal guardian

_____ Relationship to student

_____ Date

_____ Address (if different from above)

_____ Home/office phone (if different from above)

_____ City, State, Zip (if different from above)

QUESTIONS? Email NYSYBC's Adult Coordinators at ybc@nybirds.org

PLEASE FAX to: (845) 724-3431 ***or SCAN/PHOTOGRAPH & EMAIL to:*** ybc@nybirds.org
or mail completed form to: NYSOA-NYSYBC, PO Box 363, Poughquag, NY 12570

NYSOA/NYSYBC EMERGENCY MEDICAL AUTHORIZATION FORM - 2017

(to be submitted ONCE PER YEAR with the FIRST field trip permission form for each calendar year - please print)

There may be times during a NYSOA or NYSYBC event when minors become separated from their parents. This form is to enable parents and guardians to authorize the provision of emergency treatment for minors who become ill or injured when parents or guardians cannot be reached.

Student Last Name:_____ **First:**_____

Part I – Contact Information

Birthdate _____ Phone1:_____ Phone2:_____

Residential Parent or Guardian:

Mother's Last Name:_____ First:_____ Phone1:_____ Phone2:_____

Father's Last Name:_____ First:_____ Phone1:_____ Phone2:_____

Other's Last Name:_____ First:_____ Phone1:_____ Phone2:_____

Name of Relative or other secondary emergency contact:

Last:_____ First:_____ Relationship:_____ Phone1:_____

Address:_____ Phone2:_____

Part II or III must be completed.

Part II – To Grant Consent

☐ I hereby give consent for the following medical care providers and local hospital to be called:

Doctor_____ Phone_____

Dentist_____ Phone_____

Medical Specialist_____ Phone_____

Local Hospital_____ Emergency Room Phone_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:_____

_____

_____

_____

Part III – Refusal to Consent

☐ I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish NYSOA/NYSYBC authorities to take the following actions:

_____

_____

_____

Part IV – Signature

Date_____ **Signature of Parent or Guardian:**_____

Parent/Guardian's Address_____

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